DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/22/12

PRINTED: 11/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	11/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide care in an appropriate time for one resident (#11) of eleven residents reviewed. The findings included: Resident #11 was admitted to the facility on October 13, 2012, with diagnoses including Cardiomegaly, Diabetes, Anemia, and Total Knee Replacement. Continued review revealed the resident was discharged home on November 1, 2012. Medical record review of the admission Minimum Data Set dated October 20, 2012, revealed the resident required no assistance with decision making, had no problem with memory, and required moderate assistance of one person for transfers. Interview with the resident on November 6, 2012, at 3:00 p.m., in the dining room, revealed, "I was admitted to the facility on October 13, 2012, with a Total Knee Replacement. I turned my call light	F 246	"This plan of correction is submitted as required under state and federal law. The submission of this plan does not constitute an admission on the part of Horizon Health & Rehab as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The plan of correction does not constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. The plan of correction should be considered as Horizon Health & Rehab's credible letter alleging compliance."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	11/21/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 on at 12:20 a.m., (on October 14, 2012). I needed to go to the bathroom and I needed something for pain. There was no answer. At 1:04 a.m., I called my son. I told him to call up here and tell them to answer my call light. My son came in at 1:15 a.m. The CNA (Certified Nursing Assistant) was just coming into the room. My son talked with a nurse and two CNAs. The nurse stated she was not aware the light was on until the CNA came into the room because it was not sounding...The Administrator came in later that day. He stated he was glad I talked with him and this was unacceptable and he moved me to a private room. He got the call lights fixed..." Review of the medical record revealed the resident received Lortab 10/500mg (medication for pain) at 1:30 a.m., on October 14, 2012. Interview with the Administrator on November 7, 2012, at 8:00 a.m., at the nursing station, revealed, "I talked with the resident's son on October 14, 2012, regarding the resident having to wait for one hour for pain medication and being assisted to the bathroom. I discovered the call light system was not sounding. I immediately called the Maintance Director. The Maintance Director came and replaced the audible system." Interview with the Licensed Practical Nurse (#1) that was working on October 14, 2012, on November 7, 2012, at 9:15 a.m., by phone, revealed, "the resident complained the call light had been on for an hour. The light was on but it was not sounding. I was down the hall and I could not see the room. I immediately gave the resident the pain medication and the CNA assisted the resident to the bathroom. "Continued interview, at	F246	F246 Pages 1,2,3 As stated in the 2567 the nurse immediately administered Resident #11 the requested pain medication, and the nursing assistant assisted the resident to the bathroom as soon as they were notified of the resident's needs. The Maintenance Director replaced the audible system. All residents have the potential to be affected by this deficient practice. Residents will be given a bell to ring until the call light is repaired. The Maintenance Director and/or Chief Executive Officer will complete random room checks on call lights daily x 1 week, then twice weekly x 2 weeks, monthly x 2 months, then PRN. The maintenance Director will report audit findings to the Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, and Medical Director) monthly for three months, then quarterly and PRN.	

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F 246	Continued From page 2 that time, confirmed the resident had to wait for approximately one hour for pain medication and assistance to the bathroom. Medical record review revealed the resident was in room 603. Observation on November 7, 2012, at 10:00 a.m., revealed room 603 was not visible from the nursing station. Interview with the Administrator on November 7, 2012, at 10:20 a.m., at the nursing station, confirmed the resident's needs were not met for approximately one hour.	F 246	F315 A bowel and bladder assessment was completed by the Assistant Director of Nursing on Resident #10 on 11/06/2012. 100% chart review will be completed to ensure that a bowel and bladder assessment has been completed on every resident. The Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Medical Records Director will review every chart upon admission, and quarterly to ensure that a bowel and bladder assessment has been completed. The Director of Nursing will report audit findings to the Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure bladder and bowel assessments were completed for one resident (#10) of eleven residents reviewed. The findings included:	F 315		

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F 315	Continued From page 3 Resident #10 was admitted to the facility on June 29, 2011, and readmitted to the facility on December 19, 2011, with diagnoses including Pneumonia, Dysphagia, Muscle Weakness, Parkinson's Disease, and Dementia with Behavioral Disturbance. Medical record review of the Initial Minimum Data Set (MDS) dated July 8, 2011, revealed the resident was always incontinent of bladder and bowel. Further review of the Initial MDS revealed a trial toileting program had not been attempted since admission to the facility. Continued review of the Initial MDS revealed both the resident and direct care staff believed the resident was capable of increased independence in at least some activities of daily living. Interview with the Assistant Director of Nursing (ADON) on November 7, 2012, at 8:35 a.m., in the ADON's office, confirmed the facility had not completed a bladder and bowel assessment for the resident since the resident's admission on June 29, 2011.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 The dietary Manager immediately removed the roach that was killed, and the pest traps that contained roaches. All residents have the potential to be affected by this deficient practice, however no resident experienced a negative outcome related to this deficient practice.	

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain dry storage to prevent pest infestation. The findings included: Observation of the dietary department on November 5, 2012, from 11:00 a.m. until 11:30 a.m., revealed multiple pest traps located along the walls in the dry storage room. Continued observation of the dry storage room revealed the pest traps contained dead roaches. Further observation in the dry storage room revealed a live roach in the middle of the dry storage room. Interview with the Dietary Manager on November 5, 2012, at 11:20 a.m., in the dry storage room, confirmed the presence of both dead and live roaches in the dry storage room.	F 371	We will begin a more aggressive/comprehensive approach of weekly pest control intervention in this area. These services will begin on 11/20/2012, continuing throughout the year. Monitor and identify pests daily x 1 week, twice a week x 2 weeks, then weekly x 1 month, then monthly x 2 months, then PRN. Dietary Manager will ensure that proper stock rotation is completed weekly, thereby reducing cardboard and increasing sanitation. The Chief Executive Officer and/or Dietary Manager will review the stock room daily x 1 week, weekly x 2 weeks, monthly x 2 months, then PRN. The Dietary Manager will report audit findings to the Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, and the Medical Director) monthly x 3 months and PRN.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 5 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to wash hands or change gloves during a dressing change, failed to discard soiled dressings in a bio hazard container for one resident (# 4), and failed to maintain infection control practices for a urinary catheter for one resident (# 5) of eleven residents reviewed. The findings included: Observation on November 6, 2012, at 8:30 a.m.,	F 441	F441 Residents #4 and #5 did not experience a negative outcome related to the deficient practice, however the hand-washing process, and proper disposal of soiled dressings was immediately reviewed with the treatment nurse by the Vice President of Clinical Services. The foley bag for Resident #5 was cleaned and relocated to a higher area on the bed frame to life the foley bag off of the floor. All residents with a wound or foley catheter have the potential to be affected by the deficient practice. The Director of Nursing, or Vice President of Clinical Services will complete a skills check off with the treatment nurse weekly x 4 weeks, monthly x 2 months, and then PRN. The Director of Nursing, Assistant Director of Nursing, or medical Records Director will review the placement of foley bags to ensure that they are not resting on the floor. Review will be done daily x 1 week, then weekly x 2 weeks, then monthly x 2 months, and PRN.	

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F 441	Continued From page 6 revealed the facility's treatment nurse performing a dressing change on resident's (#4) sacrum. Observation revealed the treatment nurse washed the hands, applied gloves, removed the old dressing from the sacrum, discarded the soiled dressings in a plastic bag, removed gloves, washed the hands, and applied clean gloves. The treatment nurse cleansed the wound and applied a clean dressing to the sacrum without removing gloves or washing the hands. Continued observation revealed the treatment nurse placed the soiled dressings in a trash can, designated for routine trash, that was sitting in the hall way. Review of the facility's Hand Washing / Hand Hygiene Policy revealed, "...Employees must wash their hands for at least 15 seconds, using antimicrobial or non-antimicrobial soap and water under the following conditions: After handling soiled or used...dressings..." Interview with the treatment nurse on November 6, 2012, at 8:45 a.m., at the nursing station, confirmed the hands were not washed between cleansing the wound and applying a clean dressing. Continued interview, at that time, with the treatment nurse revealed, "I thought I was to use the biohazard container only when there was leakage of body fluids." Interview with the Regional Nurse on November 6, 2012, at 9:00 a.m., in the Assistant Directors of Nursing' Office, revealed, "The treatment nurse knew all soiled dressings were to be placed in a bio hazard container because he/she was in-serviced yesterday (November 5, 2012)." Resident #5 was admitted to the facility on	F 441	The Director of Nursing or Assistant Director of Nursing will re-educate all staff on infection control as relates to catheter placement by 11/28/2012. The Director of Nursing and/or Assistant Director of Nursing will provide re-education to the treatment nurse related to infection control during dressing changes by 11/28/2012. The Director of Nursing will report audit findings to the Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Assistant Director of Nursing, Social Services director, Business Office Manager, and Medical Director) monthly x 3 months, then quarterly afterwards.	

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F 441	Continued From page 7 October 12, 2012, with diagnoses including Human Immunodeficiency Virus, Toxoplasmosis, Hepatitis C and Dehydration. Observation of the resident on November 5, 2012, at 1:00 p.m., in the resident's room, revealed the resident lying on the bed with an indwelling urinary catheter tubing draining to a catheter bag hanging from the bottom frame of the resident's bed. Continued observation of the resident revealed the catheter bag to be lying on the floor. Observation and interview with Registered Nurse (RN) #1 at 1:05 p.m., in the resident's room, confirmed the resident's urinary catheter bag was lying on the floor and proper infection control standards were not maintained. Observation of the resident on November 6, 2012, at 8:07 a.m., in the resident's room, revealed the resident lying on the bed with an indwelling urinary catheter tubing draining to a catheter bag hanging from the bottom frame of the resident's bed. Continued observation revealed the catheter bag to be lying on the floor. Observation and interview with RN #1 on November 6, 2012, at 8:10 a.m., in the resident's room, confirmed the resident's urinary catheter bag was lying on the floor and proper infection control standards were not maintained.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463	+ OVER -	

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F 463	Continued From page 8 facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a working call-light system for one room of eight rooms observed. The findings included: Observation of the facility with the Maintenance Director on November 7, 2012, from 9:10 a.m. until 9:35 a.m., room numbers 603, 604, 609, 613, 401, 407, 501, and 506 were checked for working call-light system. Continued observation of the facility with the Maintenance Director, at this time, revealed, the Maintenance Director entered room 506 which was occupied by two residents, and pushed the call light. Observation of the light-up board at the 400/500 Hall Nursing Station, at this time, revealed neither the light or sound for room 506 were sounding at the 400/500 Hall Nursing Station. Observation and interview with the Maintenance Director and Assistant Director of Nursing (ADON) on November 7, 2012, at 9:35 a.m., at the 400/500 Hall Nursing Station confirmed neither the light or sound for room 506 were functioning when a call was attempted from the resident's room. Observation and interview with the Maintenance Director on November 7, 2012, at 10:15 a.m., at the 400/500 Hall Nursing Station, confirmed the	F 463	F463 The Maintenance Director immediately repaired the call light in Room 506. All residents have the potential to be affected by this deficient practice. Residents will be given a bell to ring as needed until the call light is repaired. The Maintenance Director and/or Chief Executive Officer will inspect all call lights daily x 1 week, twice weekly x 1 week, weekly x 2 weeks, then monthly x 2 months. The Maintenance Director will report audit findings to the Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Assistant director of Nursing, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then quarterly afterwards.	

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F 463	Continued From page 9 call light for room 506 had been repaired and both light and sound were working at the 400/500 Hall Nursing Station.	F 463		